

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0045880</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																
Facility Name: <u>Lydia Healthcare, LLC</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																																																																
Address: <u>13901 S. Lydia</u> <u>Robbins</u> <u>60472</u>																																																																																		
Number City Zip Code																																																																																		
County: <u>COOK</u>																																																																																		
Telephone Number: <u>(708) 385-8700</u> Fax # <u>(708) 385-5642</u>																																																																																		
IDPA ID Number: <u>36-4472404</u>		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) <u>See Accountants' Compilation Report Attached</u></td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Donald Magnuson, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td colspan="2" rowspan="2">Date of Initial License for Current Owners: <u>01/01/02</u></td><td colspan="2">(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td colspan="2">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2"></td></tr><tr><td colspan="2"><table><tr><td><input type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input checked="" type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other</td><td colspan="2">_____</td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Steve Lavenda</u></td><td colspan="2">Telephone Number: <u>(847) 236 - 1111</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) <u>See Accountants' Compilation Report Attached</u>	(Date) _____	(Print Name and Title) <u>Donald Magnuson, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	Date of Initial License for Current Owners: <u>01/01/02</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		Type of Ownership:				<table><tr><td><input type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input checked="" type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other</td><td colspan="2">_____</td></tr></table>		<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	IRS Exemption Code _____		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	"Sub-S" Corp.	_____				<input checked="" type="checkbox"/>	Limited Liability Co.	_____				<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other	_____				In the event there are further questions about this report, please contact:				Name: <u>Steve Lavenda</u>		Telephone Number: <u>(847) 236 - 1111</u>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC

0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	Skilled (SNF)			1
2	Skilled Pediatric (SNF/PED)			2
3	412Intermediate (ICF)	412	150,380	3
4	Intermediate/DD			4
5	Sheltered Care (SC)			5
6	ICF/DD 16 or Less			6
7	412TOTALS	412	150,380	7

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8	SNF				8
9	SNF/PED				9
10	ICF	140,009	1,449	3,073	144,531
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	140,009	1,449	3,073	144,531

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.11%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid? 4,363 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 01/01/02

J. Was the facility purchased or leased after January 1, 1978? YES X Date 01/01/02 NO

K. Was the facility certified for Medicare during the reporting year? YES NO X If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	310,040	77,351	15,340	402,731		402,731		402,731			1
2	Food Purchase		646,821		646,821	(50,005)	596,816	(1,547)	595,269			2
3	Housekeeping	523,826	117,760		641,586		641,586		641,586			3
4	Laundry	57,622	46,082		103,704		103,704		103,704			4
5	Heat and Other Utilities			258,296	258,296		258,296		258,296			5
6	Maintenance	335,002	42,058	250,278	627,338		627,338	(103,074)	524,264			6
7	Other (specify):*											7
8	TOTAL General Services	1,226,490	930,072	523,914	2,680,476	(50,005)	2,630,471	(104,621)	2,525,850			8
	B. Health Care and Programs											
9	Medical Director			1,000	1,000		1,000		1,000			9
10	Nursing and Medical Records	2,329,815	97,710	14,891	2,442,416		2,442,416	(18,629)	2,423,787			10
10a	Therapy			655	655		655		655			10a
11	Activities	231,164	2,578		233,742		233,742		233,742			11
12	Social Services	390,838	8,899		399,737		399,737		399,737			12
13	Nurse Aide Training											13
14	Program Transportation			5,833	5,833		5,833		5,833			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,951,817	109,187	22,379	3,083,383		3,083,383	(18,629)	3,064,754			16
	C. General Administration											
17	Administrative	81,289		142,900	224,189		224,189		224,189			17
18	Directors Fees											18
19	Professional Services			172,439	172,439	(264)	172,175	(56,838)	115,337			19
20	Dues, Fees, Subscriptions & Promotions			38,703	38,703		38,703	(14,696)	24,007			20
21	Clerical & General Office Expenses	393,882	17,442	175,505	586,829		586,829	(58,214)	528,615			21
22	Employee Benefits & Payroll Taxes			721,225	721,225	50,005	771,230		771,230			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,113	3,113		3,113	(1,273)	1,840			24
25	Other Admin. Staff Transportation			8,248	8,248		8,248		8,248			25
26	Insurance-Prop.Liab.Malpractice			297,200	297,200		297,200		297,200			26
27	Other (specify):*											27
28	TOTAL General Administration	475,171	17,442	1,559,333	2,051,946	49,741	2,101,687	(131,021)	1,970,666			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,653,478	1,056,701	2,105,626	7,815,805	(264)	7,815,541	(254,271)	7,561,270			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			36,873	36,873		36,873	468,534	505,407			30
31	Amortization of Pre-Op. & Org.							15,661	15,661			31
32	Interest			294,768	294,768		294,768	301,657	596,425			32
33	Real Estate Taxes			684,500	684,500	264	684,764	(23,162)	661,602			33
34	Rent-Facility & Grounds			3,007,596	3,007,596		3,007,596	(3,007,596)				34
35	Rent-Equipment & Vehicles			32,865	32,865		32,865		32,865			35
36	Other (specify):*											36
37	TOTAL Ownership			4,056,602	4,056,602	264	4,056,866	(2,244,906)	1,811,960			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,570	225,570		225,570		225,570			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			225,570	225,570		225,570		225,570			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,653,478	1,056,701	6,387,798	12,097,977		12,097,977	(2,499,177)	9,598,800			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	51,051	30		9
10	Interest and Other Investment Income	(11,047)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(64)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,273)	24		19
20	Contributions	(4,082)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,444)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(26,702)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(241,996)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (261,557)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,237,620)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,237,620)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,499,177)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
Lydia Healthcare, LLC		
100	0045880	
Report Period Beginning:		01/01/02
Ending:		12/31/02
		Sch. V Line
NON-ALLOWABLE EXPENSES		Amount Reference
1	VA Medical Expenses	\$ (18,629) 10 1
2	Bank Charges	(7,070) 21 2
3	Miscellaneous Income	(442) 21 2
4	Discounts Earned	(1,480) 02 4
5	ICLTC (COPE)	(7,170) 20 5
6	Finance Charges and Fees	(1,283) 32 6
7	Capitalized RAM	(163,074) 06 7
8	Loss on Disposal of Assets	(32,994) 43 8
9	Legal Fees - Not Documented	(56,838) 19 9
10	Real Estate Taxes - Late Payment Penalties	(13,013) 33 10
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101	Total	(241,996) 101

Summary A

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

12/31/02

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Susan Simonsen	50%	Winfield Woods, LLC	Winfield	Lydia Building, LLC	Winfield	Bldg. Company
William Daugherty	50%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 3,007,596	Lydia Building	100.00%	\$	\$ (3,007,596)	1
2	V	32	Interest Income	275,292	Lydia Building	100.00%		(275,292)	2
3	V	30	Depreciation		Lydia Building	100.00%	417,483	417,483	3
4	V	31	Amortization		Lydia Building	100.00%	15,661	15,661	4
5	V	32	Interest		Lydia Building	100.00%	589,279	589,279	5
6	V	33	Real Estate Taxes	684,500	Lydia Building	100.00%	674,351	(10,149)	6
7	V	43	Loss of Disposal of Assets		Lydia Building	100.00%	32,994	32,994	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 3,967,388			\$ 1,729,768	\$ * (2,237,620)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susan Simonsen	Owner	Administrative	50.00%	See Attached	10	20.00%	Mgmt. Fee	\$ 55,000	17 - 03	1
2	William Daugherty	Owner	Administrative	50.00%	See Attached	40	80.00%	Mgmt. Fee	87,900	17 - 03	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 142,900		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

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Street Address
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()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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City / State / Zip Code
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Fax Number

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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
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()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lydia Healthcare, LLC # 0045880 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	American National Bank		X	Mortgage		01/01/02	\$ 20,000,000	\$ 20,000,000			\$ 589,279	1							
2	GMAC Flexible Finance		X	Express Van	\$656.08	10/01/02	20,175	18,889		10.54%	683	2							
3	GMAC Flexible Finance		X	Venture Van	\$453.11	10/01/02	21,063	20,430		10.54%	726	3							
4												4							
5												5							
	Working Capital																		
6	American National Bank	X		Line of Credit							16,784	6							
7												7							
8												8							
9	TOTAL Facility Related				\$1,109.19		\$ 20,041,238	\$ 20,039,319			\$ 607,472	9							
	B. Non-Facility Related*																		
10	See Supplemental Schedule											10							
11												11							
12	Interest Income		X								(11,047)	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (11,047)	14							
15	TOTALS (line 9+line14)						\$ 20,041,238	\$ 20,039,319			\$ 596,425	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$		\$			\$	21

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1. Real Estate Tax accrual used on 2001 report.				\$	632,400	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	609,238	2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	(23,162)	3																			
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	684,500	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	264	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	661,602	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		1997	443,620	8	<table><tr><td colspan="3">FOR OHF USE ONLY</td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2001</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td></td><td>16</td></tr></table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2001	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$		16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION \$		16																						
	1998	458,420	9																						
	1999	576,535	10																						
	2000	574,869	11																						
	2001	609,238	12																						
2002 Real Estate Tax Accrual = \$622,251 * 1.12 = \$684,500																									

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Lydia Healthcare, LLC

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0045880

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. See Attached Schedule	Long Term Care Property	\$ 609,238.05	\$ 609,238.05
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 609,238.05	\$ 609,238.05

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Lydia Healthcare, LLC

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0045880

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 132,606

B. General Construction Type: ExteriorFrameBrick

Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred: 369,447

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 15,661

4. Dates Incurred:

Nature of Costs: Goodwill (\$197,419) / Financing Fees (\$172,028)
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1986	\$ 26,179	1
2			Various	79,586	2
3	TOTALS			\$ 105,765	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1986	\$ 3,939,267	\$ 250,334	35	\$ 112,550	\$ (137,784)	\$ 1,736,920	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	211,048		20	11,107	11,107	173,616	9
10	Various			1988	225,278		20	11,855	11,855	172,476	10
11	Various			1989	130,379		20	4,498	4,498	104,611	11
12	Various			1990	55,561		20	2,706	2,706	36,201	12
13	Various			1991	72,262		20	3,613	3,613	42,012	13
14	Various			1992	199,474		20	9,974	9,974	72,115	14
15	Various			1993	890,967		20	41,146	41,146	417,879	15
16	Various			1994	168,253		20	8,412	8,412	72,537	16
17	Various			1995	147,370		20	7,371	7,371	55,020	17
18	Various			1996	128,836		20	6,442	6,442	42,358	18
19	Various			1997	198,375		20	10,184	10,184	55,531	19
20	Various			1998	364,318		20	17,663	17,663	80,138	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69	Financial Statement Depreciation			83,158			(83,158)		69
70	TOTAL (lines 4 thru 69)		\$ 6,731,388	\$ 333,492		\$ 247,521	\$ (85,971)	\$ 3,061,414	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,731,388	\$ 333,492		\$ 247,521	\$ (85,971)	\$ 3,061,414	1
2	FLOOR TILE	1999	560		20	28	28	107	2
3	WALLPAPER	1999	5,111		20	256	256	981	3
4	CROWN MOLDING	1999	4,359		20	218	218	836	4
5	CROWN MOLDING	1999	6,452		20	323	323	1,238	5
6	WALLPAPER	1999	3,591		20	180	180	690	6
7	WALLPAPER	1999	1,210		20	61	61	234	7
8	FIRE DAMPER	1999	42,000		20	2,100	2,100	8,050	8
9	NEW PHONE EXT	1999	905		20	45	45	173	9
10	BOILER-CORR PER CODE	1999	4,000		20	200	200	783	10
11	WALLPAPER	1999	7,848		20	392	392	1,503	11
12	WALLCOVERING	1999	12,210		20	611	611	2,342	12
13	PAINT WALLS	1999	13,162		20	658	658	2,522	13
14	WALLPAPER	1999	5,251		20	263	263	1,008	14
15	BLINDS	1999	1,206		20	60	60	230	15
16	PAINT WALLS/CHAIR LF	1999	3,580		20	179	179	671	16
17	TOILET	1999	508		20	25	25	92	17
18	PAINT WALL	1999	2,467		20	123	123	472	18
19	PAINT	1999	2,362		20	118	118	452	19
20	PAINT/WALLPAPER	1999	1,070		20	54	54	207	20
21	PAINT/WALLPAPER	1999	1,081		20	54	54	207	21
22	PAINT/WALLPAPER	1999	1,265		20	63	63	242	22
23	PAINT WALLS	1999	747		20	37	37	142	23
24	WALLPAPER	1999	897		20	45	45	173	24
25	WALLPAPER	1999	1,196		20	60	60	230	25
26	PAINT WALLS	1999	805		20	40	40	153	26
27	BLINDS	1999	2,481		20	124	124	475	27
28	WALLPAPER	1999	6,653		20	333	333	1,277	28
29	CARPET/TILE	1999	3,918		20	196	196	735	29
30	COVE BASE	1999	1,460		20	73	73	274	30
31	PAINT/WALLPAPER	1999	8,135		20	407	407	1,526	31
32	LOCKS	1999	566		20	28	28	103	32
33	CHAIR RAR/COVE BASE	1999	1,113		20	56	56	215	33
34	TOTAL (lines 1 thru 33)		\$ 6,879,557	\$ 333,492		\$ 254,931	\$ (78,561)	\$ 3,089,757	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,879,557	\$ 333,492		\$ 254,931	\$ (78,561)	\$ 3,089,757	1
2	CARPET	1999	635		20	32	32	120	2
3	WALLPAPER	1999	1,102		20	55	55	206	3
4	VINYL TILE	1999	534		20	27	27	99	4
5	CROWN MOLDING	1999	3,065		20	153	153	548	5
6	CROWN MOLDING	1999	10,465		20	523	523	1,874	6
7	CROWN MOLDING	1999	3,065		20	153	153	548	7
8	CROWN MOLDING	1999	10,465		20	523	523	1,874	8
9	PAINT	1999	507		20	25	25	100	9
10	NURSE CALL SYSTEM	1999	1,630		20	82	82	287	10
11	BOWL DIFFUSER	1999	1,189		20	59	59	211	11
12	LUMBER	1999	599		20	30	30	105	12
13	FIRE DAMPER	1999	9,750		20	488	488	1,749	13
14	FLOWERING FLAT	1999	503		20	25	25	90	14
15	ANDERSON LOCK	1999	566		20	28	28	96	15
16	PAINT/WALLPAPER	1999	14,939		20	747	747	2,739	16
17	CROWN MOLDING	1999	3,734		20	187	187	670	17
18	CROWN MOLDING	1999	6,547		20	327	327	1,172	18
19	CROWN MOLDING	1999	3,625		20	181	181	649	19
20	CROWN MOLDING	1999	6,547		20	327	327	1,172	20
21	CARPETING	1999	612		20	31	31	109	21
22	WALLPAPER	1999	1,659		20	83	83	291	22
23	PAINT/WALLPAPER	1999	8,137		20	407	407	1,425	23
24	PAINT BORDER	1999	2,467		20	123	123	431	24
25	VINYL WALLCOVERING	1999	9,453		20	473	473	1,656	25
26	BLINDS	1999	1,206		20	60	60	205	26
27	BLINDS	1999	1,206		20	60	60	205	27
28	WALLPAPER	1999	717		20	36	36	123	28
29	CROWN MOLDING	1999	3,065		20	153	153	523	29
30	BORDER PAPER	1999	688		20	34	34	116	30
31	BORDER PAPER	1999	2,475		20	124	124	424	31
32	PAINT WALLS	1999	13,162		20	658	658	2,248	32
33	CROWN MOLDING	1999	10,465		20	523	523	1,787	33
34	TOTAL (lines 1 thru 33)		\$ 7,014,336	\$ 333,492		\$ 261,668	\$ (71,824)	\$ 3,113,609	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,014,336	\$ 333,492		\$ 261,668	\$ (71,824)	\$ 3,113,609	1
2	HMS	1999	4,465		20	223	223	818	2
3	WALL BUMPER	1999	4,843		20	242	242	787	3
4	WALL PLAQUES SIGN	1999	2,203		20	110	110	358	4
5	WALL PLAQUES SIGN	1999	2,204		20	110	110	358	5
6	WALL PLAQUES SIGN	1999	2,204		20	110	110	358	6
7	WALLPAPER	1999	4,902		20	245	245	796	7
8	WALLPAPER	1999	732		20	37	37	120	8
9	RUBBER COVE BASE	1999	190		20	10	10	33	9
10	WALL BUMPER	1999	4,843		20	242	242	787	10
11	INSTALL DATA CABLE	1999	3,325		20	166	166	540	11
12	VINYL WALLCOVERING	1999	4,876		20	244	244	895	12
13	PAINT WALL/BLINDS	1999	13,559		20	678	678	2,091	13
14	WALLPAPER	1999	6,027		20	301	301	928	14
15	WALL PLAQUES/SIGN	1999	2,204		20	110	110	339	15
16	NTC	1999	38,018		20	1,901	1,901	5,861	16
17	PAVING	1999	5,400		20	270	270	923	17
18	SEXAUER	1999	815		20	41	41	140	18
19	HMS	1999	1,621		20	81	81	257	19
20	HMS	1999	2,386		20	119	119	377	20
21	HMS	1999	7,533		20	377	377	1,194	21
22	HMS	1999	9,895		20	495	495	1,568	22
23	HMS	1999	12,144		20	607	607	1,922	23
24	DRYWALL	1999	550		20	28	28	84	24
25	DOORSWITCH	1999	634		20	32	32	96	25
26	NURSE CALL SYSTEM	1999	1,006		20	50	50	150	26
27	WOOD CHAIR RAIL	1999	1,113		20	56	56	168	27
28	WATER TREATMENT	1999	5,110		20	256	256	768	28
29	AIR HANDLING UNIT	1999	1,800		20	90	90	270	29
30	WALLPAPER	1999	753		20	38	38	114	30
31	PLUMBING	1999	1,809		20	90	90	270	31
32	SPRINKLER	1999	2,016		20	101	101	303	32
33	PLATE GLASS	1999	550		20	28	28	84	33
34	TOTAL (lines 1 thru 33)		\$ 7,164,066	\$ 333,492		\$ 269,156	\$ (64,336)	\$ 3,137,366	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,164,066	\$ 333,492		\$ 269,156	\$ (64,336)	\$ 3,137,366	1
2	HVAC REPAIRS	1999	1,787		20	89	89	267	2
3	HVAC REPAIRS	1999	604		20	30	30	90	3
4	FIRE SYSTEM	1999	819		20	41	41	123	4
5	FIRE SYSTEM	1999	505		20	25	25	75	5
6	WALLCOVERING-19909	2000	11,845		20	592	592	1,776	6
7	WALLCOVERING-19910	2000	1,194		20	60	60	180	7
8	WALLCOVERING-19916	2000	4,821		20	241	241	723	8
9	WALLCOVERING-19928	2000	536		20	27	27	81	9
10	WALLCOVERING-19933	2000	2,022		20	101	101	295	10
11	WALLCOVERING-19934	2000	9,329		20	466	466	1,359	11
12	WALLCOVERING-19935	2000	349		20	17	17	50	12
13	WALLCOVERING-19936	2000	1,986		20	99	99	289	13
14	WALLCOVERING-19937	2000	9,239		20	462	462	1,348	14
15	WALLCOVERING-19938	2000	392		20	20	20	58	15
16	WALLCOVERING-19947	2000	6,210		20	311	311	907	16
17	WALLCOVERING-19950	2000	9,373		20	469	469	1,368	17
18	WALLCOVERING-19951	2000	2,300		20	115	115	335	18
19	WALLCOVERING-19952	2000	138		20	7	7	20	19
20	WALLCOVERING-19958	2000	3,099		20	155	155	452	20
21	WALLCOVERING-19959	2000	1,280		20	64	64	181	21
22	WALLCOVERING-19960	2000	1,813		20	91	91	258	22
23	WALLCOVERING-19963	2000	10,143		20	507	507	1,437	23
24	WALLCOVERING-19976	2000	10,465		20	523	523	1,482	24
25	WALLCOVERING-19977	2000	1,206		20	60	60	170	25
26	WALLCOVERING-19978	2000	1,206		20	60	60	170	26
27	WALLCOVERING-19979	2000	629		20	31	31	88	27
28	WALLCOVERING-19999	2000	6,653		20	333	333	916	28
29	WALLCOVERING-20003	2000	1,294		20	65	65	179	29
30	WALLCOVERING-19507	2000	396		20	20	20	57	30
31	WALLCOVERING-20004	2000	259		20	13	13	36	31
32	WALLCOVERING-19998	2000	3,506		20	175	175	467	32
33	PAVING - 101234	2000	12,622		20	631	631	1,683	33
34	TOTAL (lines 1 thru 33)		\$ 7,282,086	\$ 333,492		\$ 275,056	\$ (58,436)	\$ 3,154,286	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 7,282,086	\$ 333,492		\$ 275,056	\$ (58,436)	\$ 3,154,286	1
2	WALLCOVERING-20024	2000	7,533		20	377	377	974	2
3	WALLCOVERING-20025	2000	2,386		20	119	119	307	3
4	WALLCOVERING-20035	2000	12,500		20	625	625	1,615	4
5	WALLCOVERING-20073	2000	58		20	3	3	8	5
6	WALLCOVERING-20074	2000	920		20	46	46	115	6
7	WALLCOVERING-20075	2000	7,120		20	356	356	890	7
8	WALLCOVERING-20076	2000	13,363		20	668	668	1,670	8
9	WALLCOVERING-20077	2000	1,194		20	60	60	150	9
10	WALLCOVERING-20078	2000	12,297		20	615	615	1,538	10
11	WALLCOVERING-20079	2000	12,297		20	615	615	1,538	11
12	WATER HEATER	2000	6,850		20	343	343	858	12
13	WALLCOVERING-20126	2000	4,688		20	234	234	527	13
14	WALLCOVERING-20127	2000	984		20	49	49	110	14
15	WALLCOVERING-20128	2000	2,263		20	113	113	254	15
16	WALLCOVERING-20139	2000	9,488		20	474	474	1,067	16
17	WALLCOVERING-20140	2000	9,488		20	474	474	1,067	17
18	WALLCOVERING-20143	2000	9,470		20	474	474	1,067	18
19	WALLCOVERING-20162	2000	1,532		20	77	77	173	19
20	WALLCOVERING-20032A	2000	4,589		20	229	229	515	20
21	WALLCOVERING-20089	2000	6,221		20	311	311	700	21
22	WALLCOVERING-200100	2000	4,589		20	229	229	515	22
23	WALLCOVERING-20168	2000	10,971		20	549	549	1,235	23
24	WALLCOVERING-20169	2000	350		20	18	18	41	24
25	WALLCOVERING-20193	2000	12,506		20	625	625	1,354	25
26	WALLCOVERING-19891	2000	3,734		20	187	187	390	26
27	WALLCOVERING-19892	2000	6,547		20	327	327	681	27
28	WALLCOVERING-19893	2000	3,734		20	187	187	390	28
29	WALLCOVERING-19894	2000	6,547		20	327	327	681	29
30	NEW DOORS	2000	8,287		20	414	414	1,208	30
31	BOOSTER HEATER	2000	1,840		20	92	92	261	31
32	DOOR LOCKS	2000	577		20	29	29	85	32
33	LIGHTING FIXTURE COV	2000	874		20	44	44	128	33
34	TOTAL (lines 1 thru 33)		\$ 7,467,883	\$ 333,492		\$ 284,346	\$ (49,146)	\$ 3,176,398	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 7,467,883	\$ 333,492		\$ 284,346	\$ (49,146)	\$ 3,176,398	1
2	SOUND SYSTEM	2000	965		20	48	48	140	2
3	TILE	2000	900		20	45	45	116	3
4	4 WATERFLOW"	2000	635		20	32	32	85	4
5	FIRE ALARM	2000	502		20	25	25	65	5
6	HEATER INSTALL	2000	1,945		20	97	97	275	6
7	TOILET	2000	871		20	44	44	117	7
8	DOOR LOCK	2000	574		20	29	29	70	8
9	FENCE & GATE	2000	995		20	50	50	125	9
10	FIRE ALARM	2000	537		20	27	27	65	10
11	SOLENOID	2000	860		20	43	43	104	11
12	FLOORING	2000	582		20	29	29	68	12
13	MAXITROL VALVE	2000	999		20	50	50	117	13
14	UNIT HEATER MOTOR	2000	795		20	40	40	83	14
15	HEATER MOTOR	2000	878		20	43	43	90	15
16	ALARM SYSTEM	2000	2,203		20	110	110	330	16
17	BLINDS	2000	1,551		20	78	78	169	17
18	CLOSED CIRCUIT	2000	4,057		20	203	203	457	18
19	HMS BLINDS	2000	4,135		20	207	207	483	19
20	WALLCOVERING-20141	2000	2,530		20	127	127	286	20
21	9TH FLOOR RENOVATION	2000	29,156		20	1,458	1,458	3,524	21
22	R & W HEATING	2000	1,130		20	57	57	138	22
23	DRAPERIES	2000	5,500		20	275	275	665	23
24	9TH FLOOR RENOVATION	2000	32,896		20	1,645	1,645	4,250	24
25	R & W HEATING	2000	5,650		20	283	283	778	25
26	SIGMA	2000	33,000		20	1,650	1,650	4,538	26
27	9TH FLOOR	2000	30,000		20	1,500	1,500	4,125	27
28	FLOORING	2000	4,525		20	226	226	527	28
29	AIR CONDITIONER	2000	1,059		20	53	53	124	29
30	PHOTO CELL	2000	2,352		20	118	118	334	30
31	SIGN	2000	2,424		20	121	121	242	31
32	SIGN	2000	2,424		20	121	121	242	32
33	WALLCOVERINGS	2001	6,534		20	327	327	545	33
34	TOTAL (lines 1 thru 33)		\$ 7,651,047	\$ 333,492		\$ 293,507	\$ (39,985)	\$ 3,199,675	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 7,651,047	\$ 333,492		\$ 293,507	\$ (39,985)	\$ 3,199,675	1
2	LABOR-LOUNGE	2001	6,325		20	316	316	527	2
3	CARPET,COVE BASE	2001	3,264		20	163	163	272	3
4	CARPET REMODEL INSTA	2001	1,578		20	79	79	132	4
5	WALLPAPER & BORDER	2001	479		20	24	24	40	5
6	CABINETY	2001	26,647		20	1,332	1,332	2,220	6
7	CABINETY	2001	18,281		20	914	914	1,523	7
8	COVE BASE CABINETY	2001	1,965		20	98	98	163	8
9	LABOR-BEAUTYSHOP INS	2001	1,535		20	77	77	128	9
10	COVE BASE VC TILE	2001	8,855		20	443	443	738	10
11	STAFF LOUNGE INSTALL	2001	4,560		20	228	228	380	11
12	SINKS,TOILETS	2001	44,928		20	2,246	2,246	3,931	12
13	INSTALL-STAFF LOUNGE	2001	3,856		20	193	193	306	13
14	PAINT	2001	7,102		20	355	355	533	14
15	INSTALL PICTURE&PAIN	2001	719		20	36	36	54	15
16	8TH & 9TH FLR.REHAB	2001	75,000		20	3,750	3,750	5,625	16
17	MINI BLINDS	2001	5,873		20	294	294	368	17
18	FLAG POLE	2001	2,238		20	112	112	131	18
19	MD CYLINDER	2001	838		20	42	42	84	19
20	LIGHTING	2001	901		20	45	45	86	20
21	FLOOR INSTALL	2001	546		20	27	27	45	21
22	CYLINDER	2001	532		20	27	27	47	22
23	CIRCUIT PANELS INST.	2001	725		20	36	36	60	23
24	FOOD SERVICE	2001	599		20	30	30	50	24
25	LOCKS	2001	578		20	29	29	46	25
26	FIXTURE	2001	707		20	35	35	58	26
27	MATERIAL & LABOR	2001	2,589		20	129	129	247	27
28	WALL PREP & PAINTING	2001	1,880		20	94	94	188	28
29	LUMBER	2001	1,028		20	51	51	94	29
30	CUSTOM DIFFUSER	2001	1,935		20	97	97	178	30
31	LUMBER	2001	1,022		20	51	51	77	31
32	PUMP MOTOR	2001	1,088		20	54	54	86	32
33	MOTOR	2001	1,863		20	93	93	124	33
34	TOTAL (lines 1 thru 33)		\$ 7,881,083	\$ 333,492		\$ 305,007	\$ (28,485)	\$ 3,218,216	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 7,881,083	\$ 333,492		\$ 305,007	\$ (28,485)	\$ 3,218,216	1
2	WIRE & AMP FUSES	2001	2,797		20	140	140	187	2
3	LABOR & TRANS EXPENS	2001	1,306		20	65	65	87	3
4	CONSTRUCTION	2001	39,560		20	1,978	1,978	2,143	4
5	MINI BLINDS	2001	17,552		20	878	878	1,024	5
6	REPAIR & MAINTENANCE	2001	11,877		20	594	594	693	6
7	CUSTOM DIFFUSER	2001	1,505		20	75	75	88	7
8	WIRING	2001	2,171		20	109	109	182	8
9	CONSTRUCTION 9TH FLO	2001	31,050		20	1,553	1,553	1,682	9
10	CONSTRUCTION 9TH FLO	2001	31,050		20	1,553	1,553	1,682	10
11	ELECTRICAL WORK	2001	3,617		20	181	181	362	11
12	LOCKS & DOOR SYSTEM	2001	570		20	29	29	39	12
13	LABOR FOR CORRIDORS	2001	2,070		20	104	104	208	13
14	SINK,FAUCET	2001	1,125		20	56	56	84	14
15	SINK & FAUCET	2001	1,828		20	91	91	159	15
16	GAS VALVE	2001	836		20				16
17	SPRINKLER REPAIRS	2001	1,093		20	55	55	110	17
18	WIRING	2001	2,978		20	149	149	248	18
19	CABINETRY	2001	4,350		20	218	218	236	19
20	CABINETRY	2001	4,350		20	218	218	236	20
21	CABINETRY	2001	4,350		20	218	218	236	21
22	CABINETRY	2001	8,714		20	436	436	472	22
23	ELEVATOR	2001	1,054		20	53	53	84	23
24	DEPOSIT FOR FLOORING	2001	30,000		20	3,000	3,000	3,250	24
25	9TH FLOOR ADD ON	2002	20,240		20	759	759	759	25
26	VINYL WALLCOVERING	2002	2,422		20	1,817	1,817	1,817	26
27	VINYL WALLCOVERING	2002	5,233		20	3,925	3,925	3,925	27
28	VINYL WALLCOVERING	2002	2,784		20	2,088	2,088	2,088	28
29	VINYL WALLCOVERING	2002	2,885		20	2,164	2,164	2,164	29
30	VINYL WALLCOVERING	2002	2,613		20	1,960	1,960	1,960	30
31	8TH & 9TH FLOOR RESIDENT ROOMS	2002	622		20	23	23	23	31
32	REPLACE SHUT OFF VALVES,WALLBOARD & BRACKETS	2002	375		20	14	14	14	32
33	WALLCOVERING 9TH FLOOR	2002	91		20	68	68	68	33
34	TOTAL (lines 1 thru 33)		\$ 8,124,151	\$ 333,492		\$ 329,578	\$ (3,914)	\$ 3,244,526	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 8,124,151	\$ 333,492		\$ 329,578	\$ (3,914)	\$ 3,244,526	1
2	HANDRAIL,CORNER GUARD,WALL BUMPER	2002	12,506		20	8,337	8,337	8,337	2
3	HAND RAILS,CORNER GUARDS	2002	9,648		20	6,432	6,432	6,432	3
4	8TH FLOOR DAY ROOM-CHAIR-RAIL,WALL BUMPER	2002	5,740		20	3,827	3,827	3,827	4
5	BLINDS	2002	370		20	15	15	15	5
6	BLINDS	2002	4,575		20	191	191	191	6
7	BLINDS	2002	1,449		20	60	60	60	7
8	CARPETING	2002	1,515		20	90	90	90	8
9	9TH FLOOR CARPET-WINDOW BAYS	2002	2,265		20	135	135	135	9
10	SAND/PATCH/PREP WALLS,DOOR FRAME & ELEVATOR D	2002	8,375		20	209	209	209	10
11	VINYL WALLCOVERING	2002	6,389		20	3,195	3,195	3,195	11
12	WALLCOVERING	2002	16,150		20	8,075	8,075	8,075	12
13	CARPETING	2002	205		20	2	2	2	13
14	CARPETING	2002	324		20	4	4	4	14
15	CUBICLE TRACK	2002	7,643		20	5,095	5,095	5,095	15
16	SINK,FAUCETS & HANDLES	2002	466		20	12	12	12	16
17	PEDESTAL SINK, FAUCETS & HANDLES	2002	482		20	14	14	14	17
18	PEDESTAL SINK, FAUCETS & HANDLES	2002	709		20	21	21	21	18
19	SINK,FAUCETS & HANDLES	2002	587		20	15	15	15	19
20	FLOORING	2002	10,000		20	667	667	667	20
21	WALK IN COOLER	2002	13,883		20	661	661	661	21
22	WALK IN COOLER INSTALL	2002	4,702		20	168	168	168	22
23	BLACK VINYL COVE BASE	2002	1,750		20	29	29	29	23
24	WALK IN COOLER INSTALL	2002	3,000		20	107	107	107	24
25	FLOORING	2002	120,288		20	5,346	5,346	5,346	25
26	INSTALL WALLS	2002	6,624		20	166	166	166	26
27	CUBICLE TRACK	2002	4,674		20	312	312	312	27
28	CROWN MOLDING	2002	8,181		20	136	136	136	28
29	CROWN MOLDING	2002	9,544		20	159	159	159	29
30	WALLCOVERING	2002	2,835		20	709	709	709	30
31	MINI BLINDS	2002	1,285		20	32	32	32	31
32	WALL COVERINGS	2002	9,169		20	115	115	115	32
33	WALLCOVERING	2002	7,142		20	1,190	1,190	1,190	33
34	TOTAL (lines 1 thru 33)		\$ 8,406,626	\$ 333,492		\$ 375,104	\$ 41,612	\$ 3,290,052	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 8,406,626	\$ 333,492		\$ 375,104	\$ 41,612	\$ 3,290,052	1
2	WALLCOVERING	2002	9,281		20	1,547	1,547	1,547	2
3	MINI BLINDS	2002	155		20	4	4	4	3
4	CUSTOM LEDGE TOPS	2002	7,210		20	60	60	60	4
5	VINYL WALLCOVERING	2002	2,949		20	737	737	737	5
6	WALLCOVERING	2002	734		20	184	184	184	6
7	ALLOCATION OF CREDIT MEMO	2002	(63,315)		20	(3,166)	(3,166)	(3,166)	7
8	WINDOWS	2002	3,840		20	160	160	160	8
9	WALLCOVERING	2002	2,595		20	2,163	2,163	2,163	9
10	WALLCOVERING	2002	24,093		20	20,078	20,078	20,078	10
11	WALLCOVERING	2002	1,261		20	1,051	1,051	1,051	11
12	WALLCOVERING	2002	1,843		20	1,536	1,536	1,536	12
13	WALLCOVERING	2002	3,031		20	2,526	2,526	2,526	13
14	WALLCOVERING	2002	24,747		20	20,623	20,623	20,623	14
15	WALLCOVERING	2002	1,464		20	1,220	1,220	1,220	15
16	WALLCOVERING	2002	2,060		20	1,717	1,717	1,717	16
17	9TH FLOOR CORRIDOR-CHAIR RAILS,ETC.	2002	26,162		20	1,090	1,090	1,090	17
18	9TH FLOOR CORRIDOR-CHAIR RAILS,ETC.	2002	2,647		20	110	110	110	18
19	CYLINDERS	2002	656		20	25	25	25	19
20	OVER BED LIGHTS	2002	1,704		20	57	57	57	20
21	PA SPEAKER CONTROL	2002	828		20	138	138	138	21
22	LAUNDRY REPAIRS	2002	707		20	93	93	93	22
23	NURSE CALL SYSTEM REPAIR	2002	949		20	47	47	47	23
24	STEAMER & DISPOSAL REPAIRS	2002	845		20	91	91	91	24
25	REBUILT DRAIN VALVE	2002	581		20	19	19	19	25
26	NURSE CALL SYSTEMS	2002	894		20	35	35	35	26
27	100 LOCKS	2002	578		20	12	12	12	27
28	INSTALLED 7 NEW ROOM PULL STATIONS	2002	984		20	25	25	25	28
29	SERVICE CALL FIRE SYSTEM	2002	500		20	36	36	36	29
30	CARPETING	2002	1,125		20	80	80	80	30
31	TILE	2002	588		20	3	3	3	31
32	100 KEY LOCKS	2002	582		20	2	2	2	32
33	CYLINDER Q LESS CORE	2002	698		20	9	9	9	33
34	TOTAL (lines 1 thru 33)		\$ 8,469,602	\$ 333,492		\$ 427,416	\$ 93,924	\$ 3,342,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 649,159	\$ 82,954	\$ 61,758	\$ (21,196)	10	\$ 332,893	71
72	Current Year Purchases	51,834	25,661	5,400	(20,261)	10	5,400	72
73	Fully Depreciated Assets	516,854				10	516,854	73
74								74
75	TOTALS	\$ 1,217,847	\$ 108,615	\$ 67,158	\$ (41,457)		\$ 855,147	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1997 VEHICLE	1996	\$	\$ 2,226	\$ 2,235	\$ 9	5	\$	76
77	FACILITY	CHEVY TRUCK	1998		1,775	1,938	163	5		77
78	FACILITY	2003 CHEVY EXPRESS VAN	2002	20,175	4,035	540	(3,495)	5	540	78
79	FACILITY	2002 CHEVY VENTURE	2002	21,063	4,213	564	(3,649)	5	564	79
80	TOTALS			\$ 41,238	\$ 12,249	\$ 5,277	\$ (6,972)		\$ 1,104	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,851,860	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 454,356	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 505,407	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 51,051	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,204,171	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 14,556
- Description: Sign Rental (\$1,485), Dietary Equipment (\$2,618), Plants (\$3,347), Wilson (\$1,911), Copier (\$952), Fax (\$2,411)
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	02 BMW	\$	\$ 13,968	17
18	Social Service	97 Chevy Lumina		4,341	18
19					19
20					20
21	TOTAL		\$	\$ 18,309	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 508,338	\$ 508,338	1
2	Cash-Patient Deposits	80,246	80,246	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,986,097	2,986,097	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,705	71,705	6
7	Other Prepaid Expenses	6,176	6,176	7
8	Accounts Receivable (owners or related parties)	512,306	3,616,727	8
9	Other(specify): See Supplemental Schedule	576,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,740,868	\$ 7,269,289	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,765	13
14	Buildings, at Historical Cost		6,871,530	14
15	Leasehold Improvements, at Historical Cost	168,657	2,900,066	15
16	Equipment, at Historical Cost	226,525	1,762,156	16
17	Accumulated Depreciation (book methods)	(36,873)	(6,025,448)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	5,460,000	86,237	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,818,309	\$ 5,700,306	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,559,177	\$ 12,969,595	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,151,113	\$ 1,151,113	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	74,821	74,821	28
29	Short-Term Notes Payable	10,003	10,003	29
30	Accrued Salaries Payable	241,056	241,056	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,731	14,731	31
32	Accrued Real Estate Taxes(Sch.IX-B)		684,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,491,724	\$ 2,176,224	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	29,316	29,316	39
40	Mortgage Payable		20,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	5,412,927		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,442,243	\$ 20,029,316	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,933,967	\$ 22,205,540	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,625,210	\$ (9,235,945)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,559,177	\$ 12,969,595	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,691,269	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,691,269	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,581,370	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	(3,227,441)	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(419,988)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (66,059)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,625,210	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,929,023	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,929,023	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,047	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,047	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,739,277	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,739,277	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,679,347	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,680,476	31
32	Health Care	3,083,383	32
33	General Administration	2,051,946	33
	B. Capital Expense		
34	Ownership	4,056,602	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	225,570	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,097,977	40
41	Income before Income Taxes (line 30 minus line 40)**	3,581,370	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,581,370	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lydia Healthcare, LLC

0045880

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,256	2,496	\$ 44,615	\$ 17.87	1
2	Assistant Director of Nursing	3,556	4,152	81,199	19.56	2
3	Registered Nurses	3,921	4,428	83,375	18.83	3
4	Licensed Practical Nurses	62,413	67,776	1,158,134	17.09	4
5	Nurse Aides & Orderlies	103,185	110,434	926,492	8.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	24,036	27,068	231,164	8.54	10
11	Social Service Workers	32,601	35,862	390,838	10.90	11
12	Dietician					12
13	Food Service Supervisor	9,840	10,931	113,033	10.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,283	28,375	197,007	6.94	15
16	Dishwashers					16
17	Maintenance Workers	28,584	31,195	335,002	10.74	17
18	Housekeepers	66,511	70,857	523,826	7.39	18
19	Laundry	7,205	7,734	57,622	7.45	19
20	Administrator	1,240	1,800	57,417	31.90	20
21	Assistant Administrator	848	864	23,872	27.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,038	33,290	393,882	11.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,000	2,080	36,000	17.31	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	405,517	439,342	\$ 4,653,478 *	\$ 10.59	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	386	\$ 15,340	01-03	35
36	Medical Director	Monthly	1,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10-03	39
40	Physical Therapy Consultant	12	655	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dental	Monthly	2,575	10 - 03	47
48					48
49	TOTAL (lines 35 - 48)	398	\$ 20,170		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	617	11,716	10-03	52
53	TOTAL (lines 50 - 52)	617	\$ 11,716		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Marcita Carter	Administrator		\$ 57,417	Workers' Compensation Insurance	\$	57,616	IDPH License Fee	\$
Gerado Patacil	Asst. Admin.		23,872	Unemployment Compensation Insurance		75,050	Advertising: Employee Recruitment	4,721
				FICA Taxes		301,494	Health Care Worker Background Check	
				Employee Health Insurance		120,053	(Indicate # of checks performed)	
				Employee Meals		50,005	Advertising and Promotion	3,444
				Illinois Municipal Retirement Fund (IMRF)*			Dues - ICLTC	11,218
				Pension		16,547	Dues and Subscriptions	230
				Employee Welfare		10,692	Licenses and Fees	7,838
				Union Health & Welfare		47,600		
				Employee Benefits		80,599		
				Employee Physicals		11,574		
							Less: Public Relations Expense	()
							Non-allowable advertising	(3,444)
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 81,289	TOTAL (agree to Schedule V, line 22, col.8)		\$ 771,230	TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Susan Simonsen - Management Fees			\$ 55,000				Out-of-State Travel	\$
William Daugherty - Management Fees			87,900					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 142,900					
(Attach a copy of any management service agreement)							Seminar Expense	1,840
C. Professional Services							Entertainment	1,273
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting/Data Processing		\$ 86,401					
Paychex	Payroll Processing		14,710					
Econocare, Inc.	Purchasing Consultant		774					
Personnel Planners	Unemployment Consultant		4,020					
Senior Living Systems	Data Processing		6,318					
Medi.com	Data Processing		800					
Levenfeld Pearlstein	Legal		30,153					
Shefsky & Forelich, Ltd.	Legal		19,394					
Anthony Graefe & Associates	Legal		2,313					
Harris, Kessler & Golstein	Legal		3,527					
Tenney& Bentley	Legal		264					
Others	Legal		3,764					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 172,439	TOTAL			Entertainment Expense	(1,273)
(If total legal fees exceed \$2500 attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,840

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		Lydia Healthcare, LLC	STATE OF ILLINOIS	#	0045880	Report Period Beginning:	01/01/02	Ending:	12/31/02	Page 23
XX. GENERAL INFORMATION:										
(1)	Are nursing employees (RN,LPN,NA) represented by a union?					<u>Yes</u>				
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.					<u>Yes</u> <u>ICLTC \$18,388</u>				
(3)	Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report?									
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity?									
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?					<u>Yes</u> <u>10 Years</u>				
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.					\$ <u>N/A</u> Line <u></u>				
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.									
(8)	Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease.									
(9)	Are you presently operating under a sublease agreement?					<u></u> YES <u>X</u> NO				
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>X</u> NO <u></u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.					<u>Lydia Healthcare Center #0031807</u>				
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. This amount is to be recorded on line 42 of Schedule V.					\$ <u>225,570</u>				
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.									
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?					<u>N/A</u>				
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.									
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>50,005</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ <u></u>									
(16)	Travel and Transportation									
	a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation.									
	b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u></u>									
	c. What percent of all travel expense relates to transportation of nurses and patients? <u>100%Ln14</u>									
	d. Have vehicle usage logs been maintained? <u>N/A</u>									
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>									
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>									
	g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u></u>									
(17)	Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u></u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u></u> If no, please explain. <u></u>									
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u>									
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees									

SEE ACCOUNTANTS' COMPILATION REPORT